MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STANDARD CERTIFICATE OF DEATH

Arizona State Board of Health

BUREAU OF VITAL STATISTICS

STATE FILE NO. _____

1. PLACE OF DEATH

COUNTY Graham STATE ARIZONA REGISTERED NO. _____

TOWNSHIP _____ OR VILLAGE _____ OR

CITY Safford NO. _____ ST. _____ WARD

(IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER)

LENGTH OF RESIDENCE IN CITY OR TOWN WHERE DEATH OCCURRED ____ YRS. ____ MOS. ____ DS. HOW LONG IN U. S. IF OF FOREIGN BIRTH? ____ YRS. ____ MOS. ____ DS.

2. FULL NAME WISH, C.L. (Dr.) HOW LONG IN STATE WHEN DEATH OCCURRED? ____ YRS. ____ MOS. ____ DS.

(A) RESIDENCE: NO. _____ ST. _____ WARD. _____

(USUAL PLACE OF ABODE) (IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (WRITE THE WORD)
M	American	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS	MONTHS	DAYS	IF LESS THAN 1 DAY, ____ HRS. OR ____ MIN.
37			

OCCUPATION

8. TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SPINNER, SAWYER, BOOKKEEPER, ETC. _____

9. INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS SILK MILL, SAW MILL, BANK, ETC. _____

10. DATE DECEASED LAST WORKED AT THIS OCCUPATION (MONTH AND YEAR) _____

11. TOTAL TIME (YEARS) SPENT IN THIS OCCUPATION _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Arkansas

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) _____

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) _____

17. INFORMANT _____
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Safford DATE 1/28/03 19____

19. EMBALMER { LICENSE NO. _____ { SIGNATURE _____
FUNERAL DIRECTOR _____
ADDRESS _____

20. FILED _____, 19____ _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-22-04, 19

22. I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM _____, 19____, TO _____, 19____

I LAST SAW H____ ALIVE ON _____, 19____; DEATH IS SAID TO HAVE OCCURRED ON THE DATE STATED ABOVE, AT _____ M.

THE PRINCIPAL CAUSE OF DEATH AND RELATED CAUSES OF IMPORTANCE WERE AS FOLLOWS:	DATE OF ONSET
Gun shot wounds	
OTHER CONTRIBUTORY CAUSES OF IMPORTANCE:	

NAME OF OPERATION _____ DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? _____ WAS THERE AN AUTOPSY? _____

23. IF DEATH WAS DUE TO EXTERNAL CAUSES (VIOLENCE) FILL IN ALSO THE FOLLOWING:
ACCIDENT, SUICIDE, OR HOMOCIDE? _____ DATE OF INJURY _____, 19____

WHERE DID INJURY OCCUR? _____
(SPECIFY CITY OR TOWN, COUNTY AND STATE)

SPECIFY WHETHER INJURY OCCURRED IN INDUSTRY, IN HOME, OR IN PUBLIC PLACE _____

MANNER OF INJURY _____

NATURE OF INJURY _____

24. WAS DISEASE OR INJURY IN ANY WAY RELATED TO OCCUPATION OF DECEASED? _____

IF SO, SPECIFY _____

(SIGNED) W.E.Platt, M. D.

(ADDRESS) _____